Maternal and Infant Health Program

Presented
By

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MIHP

Training Objectives

- Understand evaluation data findings related to the Maternal/Infant Support Services Programs
- Understand design process for developing the Maternal Infant Health Program (MIHP)
- Understand program components of MIHP
- Describe domains, best practice interventions and outcome indicators for MIHP

Background

- Maternal Support Services (MSS) was initiated in 1987 and Infant Support Services several years later
- The programs were designed to help reduce infant mortality and morbidity by alleviating the high educational deficits and psychosocial, nutritional, and transportation problems of high-risk, low-income pregnant women

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Design Process

Steering Committee

15 state agency personnel and project consultants

Design Workgroup

Consisting of the MIHP Steering Committee members plus representatives of 18 key stakeholder groups

Stakeholder Group

Consisting of an unlimited number of persons who wish to receive periodic updates about the work of the MIHP Design Workgroup and Steering Committee

Maternal Infant Health Program MDCH Website

www. Michigan.gov/mdch

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Pregnant Women Children and Families

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Children and Families

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Scroll down to: Maternal Infant Health Project

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Long Term Goal

To reduce maternal and infant morbidity and mortality

Immediate Program Goal

To improve the health and well being of Medicaid–eligible pregnant women and infants through a standardized, system-wide process to:

- **Screen all Medicaid-eligible women for key risk factors**
- **Assign risk stratification**

Immediate Program Goal
(continued)

- Engage all Medicaid-eligible women
- Deliver targeted interventions
- Measure specific outcomes

Program Design Criteria

1. Focus on a healthy mother who has the knowledge and skills to maximize her baby's health and overall development
   a. Serve the mother-infant dyad
   b. Begin in pregnancy

Design Criteria (continued)

2. A system-wide, integrated, seamless approach, connecting women to support resources and community services
    a. Integrate with other existing supports and services as soon as the pregnancy is confirmed
    b. Integrate with medical home
3. Population management model

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Design Criteria (continued)

4. Stratification of the population based on defined key risk factors
5. Use of proven and promising approaches, including innovative technology
6. Strong effort to engage and serve high-risk, hard-to-reach families
7. Continuity of worker/family relationship:
    a. Same worker connects with family,
    b. Develops a trusting relationship,
    c. Maintains the relationship over time

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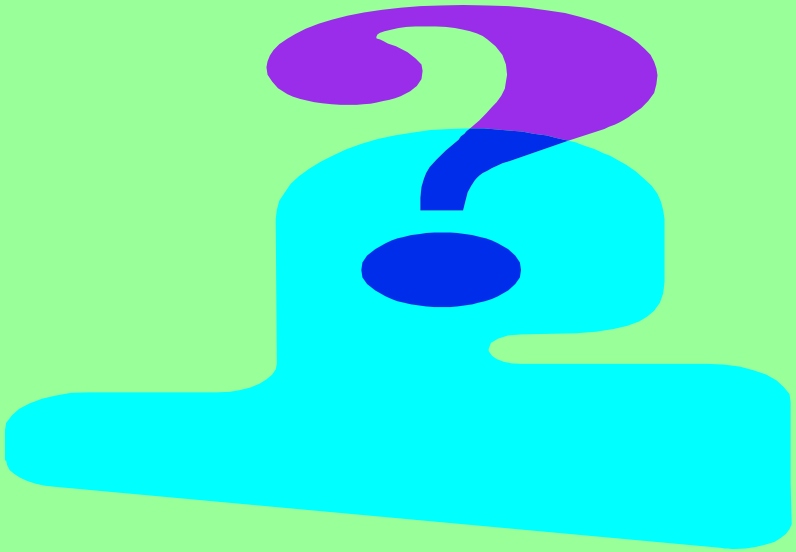
Design Criteria (continued)

8. Continual quality improvement
9. Ongoing data collection and evaluation
10. Value purchasing approach utilizing a funding mechanism that supports program goal and objectives
    a. Performance-based
    b. Actuarially sound
    c. Contracting with expected performance thresholds for clinical, utilization and service outcomes

Design Criteria (continued)

11. Spending in keeping with available resources

COMMENTS & QUESTIONS



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Population Management Model

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Population Management Model

- A system of coordinated health care and support interventions for populations with conditions in which the individual's self-care efforts are significant

Population Management

- Population-based
- Systematic
- Data-Driven
- Application of the QI process
  (Plan, Do, Study, Act)
- Outcome focused

Population Management Program Components

- Data analysis and planning
- Evidence-based interventions
- Population identification
- Registry/Centralized Data Base
- Population Stratification
- Interventions
- Outcome measurement reporting and analysis

Data Analysis and Program Planning

- High-cost, high-frequency risk conditions identified
- Conditions amenable to intervention
- Evidence-based interventions
- Sufficient resources
- Organizational commitment
- Goal: measurable, realistic, attainable within an acceptable time frame

Evidence-based Interventions

- Based on evidence
- Used to develop interventions and outcome measures
- Reduce variation
- Address defined risk domains
- Include best practice guidelines, evidence based interventions, promising practices and innovative technology

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Population Identification

- Systematic
- Criteria-based
- Potential program referral sources identified

Registry/Centralized Database

- Includes all eligible and enrolled individuals
- Tracks stratification, recommended vs. actual services, service status, interventions, utilization, cost, outcomes
- Links outcomes to profiling to incentives for providers

Population Stratification

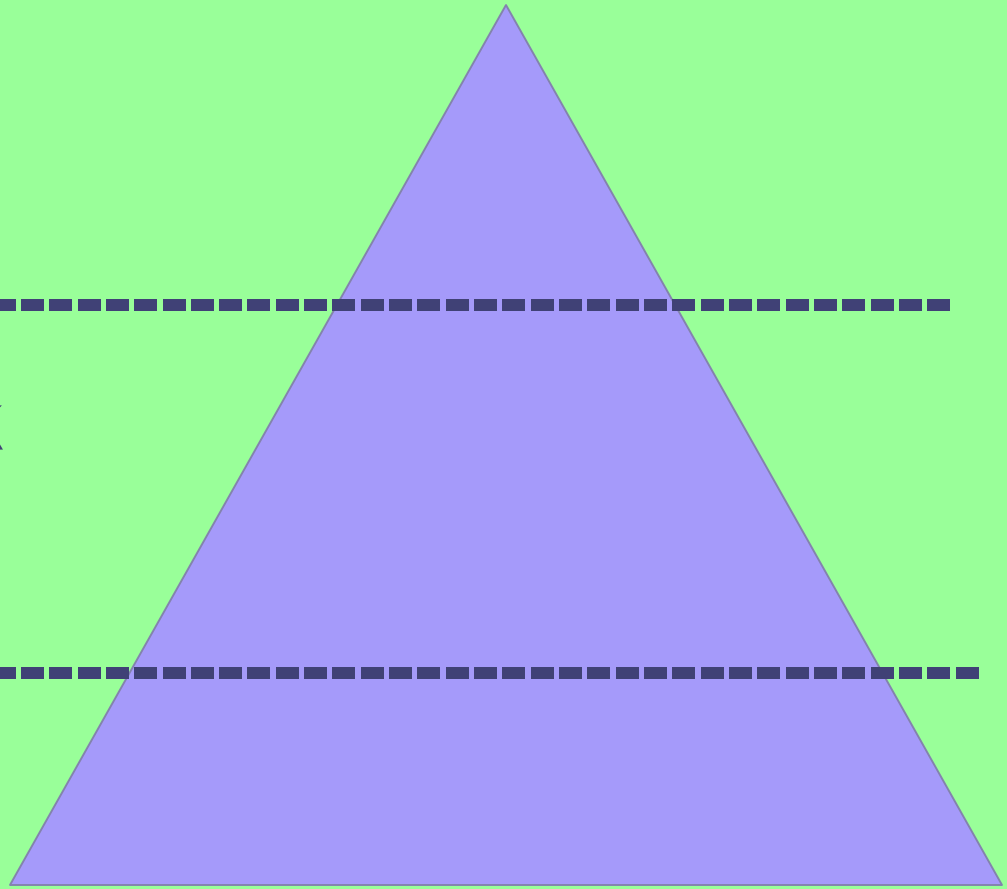
- Systematically identifies individuals according to severity of risk
- Supports prioritization of existing program resources
- Allows prioritization of resource allocation at the participant level
- Utilizes a data-driven approach
- Is dynamic, may change as the individual's circumstances change

Population Stratification-schematic

High Risk

Moderate Risk

Low Risk



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Interventions

- Identify and apply evidence-based interventions within each stratification level for each risk/outcome area

Outcome Measurement and Reporting and Analysis

- Relevant population based indicators (relative to stratification and risk/outcomes)
- Quantifiable
- Standardized measures of performance
- Participant input
- Provider input

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Outcome Measurement and Reporting and Analysis
(continued)

- Participant, process and administrative outcomes
- Defined efficient, effective, consistent and timely reporting processes
- Analysis used in ongoing program improvement

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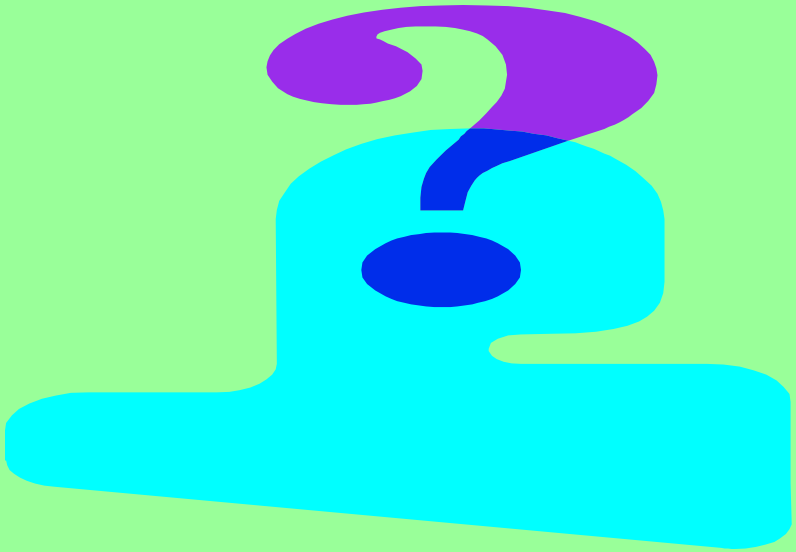
COMMENTS & QUESTIONS



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MIH Program Components

Service Administration

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Service Components

1. **Outreach** (maximize natural and existing access points)
2. **Universal screening tool** (to identify risk stratification levels)
3. **Relevant uniform assessments**
4. **Linkage to other relevant resources**
5. **Focused Care Plan that identifies outcomes and interventions using a person/family centered process**

Service Components (continued)

6. **Implementation of best practice interventions by stratification and outcomes**
7. **Care Coordination**
   a. **Point in time**
   b. **Over time**

Service Components (continued)

c. Integration with medical home
d. Coordination with other resources and providers
e. Ongoing evaluation of activities relative to outcome objectives
f. Revised care plans as needed
g. Person and family centered process

Administrative Components

1. Centralized MDCH program management
    a. Technical assistance and support
    b. Quality and Program Advisory Committee
2. Performance Based Contracting with MDCH
3. Centralized Database

Administrative Components
(continued)

4. Use of web-based applications and state-of-the-art information technology for both service and administrative functions
5. Provider performance feedback (two-way data exchange)

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Administrative Components
(continued)

6. Increased expectations over time
7. Reimbursement shift from fee-for-service to multi-tier reimbursement rates based on risk level and service intensity
8. Billing and reporting capacity (IT infrastructure)
9. Built-in performance incentives
10. Local community network agreements

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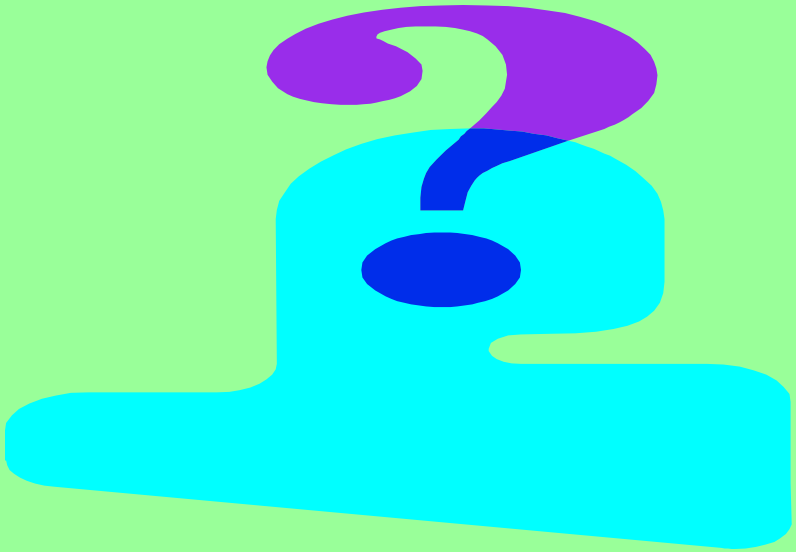
COMMENTS & QUESTIONS



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